EXHIBIT E

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CHRISTOPHER J. CUNIO
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~ADMITTED IN TEXAS ONI
*ALSO ADMITTED IN RHODE ISLAN
†ALSO ADMITTED IN CONNECTICU
°ALSO ADMITTED IN NEW HAMPSHI
♦ALSO ADMITTED IN ARIZON
○ ALSO ADMITTED IN NEW JERSI
● ALSO ADMITTED IN PENNSYLVAN
- ADMITTED IN RHODE ISLAND ONI

**VIA FIRST CLASS MAIL**

April 18, 2006

Flavia Benitez
PO Box 2437
Jamaica Plain, MA 02130

RE: Flavia Benitez v. Sodexho Marriott Services
U.S. District Court, Civil Action No.: 04-CV-11959-NG

Dear Ms. Benitez:

Enclosed please find an Authorization to Obtain, Use and Disclose Protected Health Information from Somerville Hospital. Somerville Hospital will not release any of your records until this enclosed form is signed by you and returned to them. As such, I ask that you please sign the enclosed form and return to me on or before April 25, 2006.

Although the Authorization to Disclose Information that you signed on March 23, 2006, was sent to the Somerville Hospital, the facility informed me that this Authorization was not sufficient to obtain the release of your records. The facility stated that unless it receives either an executed version of the enclosed form, or a court order, your records will not be released.

Should you have any questions or concerns, please do not hesitate to contact me. Thank you for your anticipated cooperation in this matter.

Very truly yours,

Brian M. Haney

enclosure

158410-1

Cambridge Health Alliance
A COMMUNITY OF CARING



# THE CAMBRIDGE HEALTH ALLIANCE
## AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Request for Copies of Medical Records X  Request to Review Medical Records ____

Medical Record # ____

Patient Name: Benitez (Last) Flavia (First) ____ (Middle)

Home Address: PO Box 2437 Jamaica Plain

State: MA ZIP: 02130

Home Telephone: (508) 345-5380 Date of Birth: 10/05/1954

I authorize (name of hospital/person) Somerville Hospital to: ☐ Obtain from

☒ Disclose to ☐ Communicate with

Name/Facility: Cooley Manion Jones LLP

Address: 21 Custom House Street, Boston

State: MA ZIP: 02110 Phone: (617) 737-3100 Fax: (617) 737-0374

Attention: Brian Haney, Esq.; Keith McLean, Esq.; Ken Martin, Esq.

Disclose the following information for treatment dates January 1, 1996 to Present

☒ Entire Medical Record OR

☐ Face Sheet ☐ Admission Note ☐ History & Physical ☐ Progress Notes

☐ Consults ☐ Lab Reports ☐ Pathology Reports ☐ X-ray/Scan/Imaging Reports

☐ Operative Reports ☐ Emergency Reports ☐ Physical Therapy Notes ☐ Clinic Notes

☐ Medication Notes ☐ Treatment Plan ☐ Discharge Summary

☐ Abstract (Discharge Summary, History & Physical, Operative, Pathology & Test Reports)

☐ Other ____

The purpose of this disclosure is: ☐ Medical Care ☒ Legal Matter ☐ Insurance ☐ Personal

☐ Other ____

TERM: This Authorization expires /terminates/ends:

☒ 90 days from the date signed ☐ On Other date, reason or event ____

By my signature below, I hereby authorize Cambridge Health Alliance to obtain, use and/or disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

I understand that once Cambridge Health Alliance discloses my health information to the recipient, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Cambridge Health Alliance's treatment of me; except, however, if my treatment at Cambridge Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Cambridge Health Alliance may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cambridge Health Alliance's Privacy Office at the address listed below. The revocation will be effective immediately upon Cambridge Health Alliance's receipt of my written notice, except that

Cambridge Health Alliance
A COMMUNITY OF CARE

the revocation will not have any effect on any action taken by Cambridge Health Alliance in reliance on this Authorization before it received my written notice of revocation.

I may contact Cambridge Health Alliance's Privacy Officer by mail at 432 Columbia St. Suite 15/16C Cambridge, MA 02141 or through any of CHA hospital's H.I.M. Departments (listed at the bottom of the page).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cambridge Health Alliance to obtain, use and/or disclose my health information in the manner described above.

X _____

**Signature of Patient** **Date**

**If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:**

| Signature of Personal Representative | Description of Authority | Date |
|---|---|---|
| | | |

## MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below, I specifically authorize obtaining, using and/or disclosing the type of highly confidential information indicated next to my signature, if any such information will be obtained, used or disclosed pursuant to this Authorization.

- Information about a Mental Illness, Behavioral Health or Developmental Disability _____
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional _____
- Information about HIV/AIDS Testing, Status or Treatment _____ (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s) Status or Treatment _____
- Information about Substance (i.e., alcohol or drug) Abuse Status or Treatment _____
- Information about Abuse of an Adult with a Disability _____
- Information about Sexual Assault _____
- Information about Child Abuse and Neglect _____
- Information about Genetic Testing _____
- Information about abortion _____
- Information about mammography _____
- Information about family planning services _____
- Information related to mental health community program records _____
- Information about research involving controlled substances _____
- Information about domestic violence _____
- If I am an emancipated minor, information about treatment and diagnosis (except to my parents) _____

**DATE:** _____

| The Cambridge Hospital | Somerville Hospital | Whidden Memorial Hospital |
|---|---|---|
| 1493 Cambridge Street<br>Cambridge, MA 02139 | 230 Highland Avenue<br>Somerville, MA 02143 | 103 Garland St.<br>Everett, MA 02149 |
| HIM Department<br>Release of Information Section<br>617-665-1058 | HIM Department<br>Release of Information Section<br>617-591-4127 | HIM Department<br>Release of Information Section<br>617-381-7127 |